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February 17, 2017

Public Comment on HHS Proposed PPACA Regulations - **ID: CMS-2017-0021-0001**

Thank you for the opportunity to submit Public Comment related to PPACA Regulations for 2018; and the opportunity to propose alternative recommendations for the program compared to how it operates today. Please feel free to contact me with questions; and for more detailed explanations, including the reasoning behind the recommendations. I am willing to travel and participate in future discussions.

I provide a short summary, followed by a background section detailing issues and opportunities related to how the program operates today and explaining my recommendations in more detail. The provided recommendations are based on my experience working with 1,000's of Individuals and Small Business owners as a Health Insurance Agent and Health Insurance Consultant. The recommendations focus on using a common-sense approach, while reducing the unmanageable administrative burdens, which have increased significantly over the last four years. In CT, I have witnessed how an Exchange Board, caught up in bureaucratic politics, allowed their complacency to hurt many people, on a widespread basis; and lead to an uncompetitive marketplace and an accelerating health insurance marketplace death spiral.

Summary

I recommend the elimination of the Marketplaces and allowing the insurance carriers to direct-sell their products to consumers. The marketplaces are redundant and their bureaucratic management teams have no performance-based incentives to get people enrolled, or keep them enrolled. The insurance carriers will then be able to work directly with consumers to get them enrolled and keep them enrolled. Today, the Exchange's control the enrollments and the carriers have almost no flexibility to work with their own clients. This would result in reduced program Administrative costs; and the insurance carriers have already created a redundant system, due to the administrative issues of working with the Exchange's.

I recommend eliminating the Actuarial Value Calculator and assigning health insurance plans based on the per-person maximum-out-of-pocket expenses (MOOP), ex. $6,000 for a Silver Level Plan; and expanding the Tier system with a 50/50 cost-sharing Copper Level Plan option. I recommend changing the current Subsidy system that requires people to predict future income, as it is incredibly flawed and needs to be replaced. I recommend, for ease of Subsidy administration and compliance, either Income-Based health plans, similar to Medicare Advantage Plans, or a "Flat" per-person level of assistance be made available to households earning less than $100,000/yr. per adult, or 2.5 times that for family, with no payback requirement below the set income level. I recommend keeping Guaranteed Issue in health plans and continuing with all the current existing Essential Health Benefits, for ease of a transition period; and an allowance could be made for religious employers to opt out of benefits without the need for special approval, as long as employees have available alternative options.

In regards to enrolling people in health plans, by eliminating the AV Calculator, health plans would not have to change annually; and therefore, people can keep the exact same plan, easing administration. The open enrollment period of six (6) weeks is more than adequate, assuming people are not forced to change plans annually. A consideration should be given to changing the Open Enrollment period to an alternate time of year, for example, after tax time, Apr 15 through May 31, with a July 1 effective date; however, this can realistically only be accomplished if the Subsidy is a Flat rate per month. When people enroll, if they do owe back premiums, the insurance carriers should be required to provide flexibility in the repayment, allowing people to get insurance in a timely manner and pay back-debt on a payment plan.

Overall, the major issues with the current PPACA marketplaces is that they are designed with a 'theoretical and bureaucratic' approach to insuring people, as opposed to a commonsense and practical human behavioral approach; or allowing for competitive marketplaces. The marketplaces have proven that the new bureaucratic system that has been created is unmanageable, unaccountable and inefficient; and has led to a complete destabilization of the health insurance marketplaces throughout the Country.

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Recommendation Details

In this section, I provide further reasoning to the recommendations I provided in the summary of recommendations I am submitting as public comment on CMS-2017-0021-0001.

Eliminate the State and Federal Marketplaces and Return to Private Marketplaces

- The current marketplaces are extremely complicated, cumbersome and expensive to operate; and the insurance carriers have had to create duplicate systems to help people navigate the Exchange's.
- The primary roles of the Exchanges are to Enroll People and coordinate Subsidies. Over the last four (4) years, they have not performed well; and the management teams have not been held accountable as they are composed of bureaucrats that are not evaluated on their effectiveness.
- Some of the Exchanges have expanded their roles into other marketplace sectors and left consumers with little help in enrollment support, leading to a now increasing uninsured rate.

Eliminate the Actuarial Value Calculator (AVC) – Replace with Standardized Tier MOOPS

- The AVC has fundamentally destroyed the national health insurance marketplace. It allows for no creativity on health plan designs; and basically, it forces all health plans to be the same, other than the annual Maximum Out-Of-Pocket expenses (MOOP) paid by an individual insured.
- The AVC is based on all people being "average" consumers of health care resources, meaning that all people will go to providers each-and-every year for the expected annual number of services. While this is feasible in 'theory', it is far from reality. In reality, people that expect to need healthcare purchase higher tier plans knowing that they will have lower costs when they access the healthcare they need, while those that don't expect to need healthcare purchase the cheapest plans.
- The 'reality' is that the AVC does not account for human behavior; and therefore, under-values the Platinum and Gold Tier plans, while over-valuing the Bronze and Silver Tier plans, based on how people actually make purchasing decisions.
- Instead of the AVC determining the Tiers for the health plans, the most realistic approach would be to simply "set" a MOOP for each Tier. The pre-set MOOP amount for the Tier Level then qualifies the health plan for that Tier Level. For example; the MOOP's could be set as a per-person maximum of $2,000 per Tier Level, meaning a Silver Plan would have a $6,000 per person annual maximum, while a Bronze Plan would be $8,000, and a (potential) Copper Plan would be $10,000.
- Without the AVC pre-determining what the co-payments and co-insurance, the insurance carriers would then be free to design competitive programs that have a MOOP that fits the appropriate Tier.

Replace the Current Subsidy System with an Alternate System

- The current method for determining and providing Subsidies is inherently backwards, to be polite. Asking someone to 'predict' their future income is impossible; and in essence, the system disincentives a person from trying to earn more income than they expect to earn, due to having to pay back the Subsidy, and maybe more, at tax time.
- The chart for calculating what percentage of income a person pays for their insurance is also complicated and creates 'cliffs' at set dollar amounts that make it extremely difficult for the average person/family to plan around for the future.
- Whatever decisions are made for providing assistance to people for the future need to be more realistic; and need to not punish people for finding employment, working more hours and bettering themselves and their families.
- (A Method) There has been discussion in the media about Medicare Advantage plans serving 'as a template' for how assistance can be provided to people. In essence, a set of options of Managed Care health plans could be sold direct-to-consumer by the health insurance companies; and the plan options and costs available to people buying health insurance plans could be based on their family income. Whatever Subsidy is provided for the health plan purchase can then be provided direct to the insurance company, instead of through a health insurance exchange as an intermediary.

    - There could be $0 cost plans, as there are today with Medicare Advantage, and the lower income people that qualify today for Cost-Sharing Reduction (CSR) plans would be provided with specific health plan options for which only they are eligible to enroll. If the income changes, then, at renewal, people would have to change health plans, instead of the current Subsidy system that tries to track monthly changes.
- (A Method) This is another option that has been mentioned in the media; and is probably the most commonsense and simplest option to implement, from a consumer and administrative perspective. Instead of the current Subsidy system, provide people with a pre-determined amount of financial assistance, based on their age and/or income bracket, with a margin of leeway for their future earnings, without a penalty. For example; a 40-yeard old person earning less than $100,000 per year could be allocated $200 per month to purchase a health plan of their choice. As long as their income remains under $100,000, there would be no payback of the assistance; and if there is payback of assistance required, a contribution to an HSA account could be an alternate to a penalty payment.
    - It would be very important to keep the assistance at a level that Employer-based plans would remain as a competitive option. If the average Individual health insurance plan costs less to purchase than an Employer plan, it would disrupt the Employer-plan marketplace.

Keep Guaranteed Issue and the Existing 10 Essential Health Benefits
- It is important for people to be able to purchase health insurance on a guaranteed basis; and for there to be a required standard list of covered healthcare benefits, including keeping preventive healthcare benefits covered at $0 cost.
- People need to know they can purchase health insurance, even if it means they are placed in a pool with other high risk individuals, at a reasonable cost. However, it would probably be best to create a National pool that acts as a Reinsurance policy for the State-based pools.
- State populations and local health care issues and costs vary widely, and a Reinsurance program that reinsures State pools, would help keep the costs down for most people, while spreading the costs for the small percentage of high cost insureds nationally.

Open Enrollment Change for 2018 and Beyond
- With regards to reducing the open enrollment period to six (6) weeks, from Nov 1st to Dec 15th, it is a more than reasonable time period, as long as health plan designs are not forcibly changed every year, an issue only recently created by the PPACA Actuarial Value Calculator.
- A consideration should be given to changing the Open Enrollment period to an alternate time of year, for example, after tax time, Apr 15th to May 31st, with a July 1 effective date; however, this can realistically only be accomplished if the Subsidy is a Flat pre-set rate on a per month basis.
- One potential benefit for having a mid-year Open Enrollment, that is off-cycle with Medicare, is that it could help level employment throughout the year at health insurance companies and at health insurance agencies, instead of creating a significant need for seasonal help from Sep to Jan.

Enrollment Policies, Procedures and Support
- With regard to people with past due premium balances having to re-pay the balance when they re-enroll, insurance carriers should be required to provide multiple and flexible repayment options, allowing people to get insurance in a timely manner while they pay back-debt on a payment plan.
- When people sign up during a SEP, the allowance of starting their health plan one (1) month in advance is reasonable; however, consideration should be given to COBRA coverage offered by employers, as people get two (2) months to decide between employer COBRA or purchasing their own insurance. I recommend aligning the options and providing people with the entire two (2) month period for making a decision on which coverage is better for them and their families, considering employers are allocated one (1) month to mail out the letters.
- Health insurance plan purchasing is a very difficult and confusing process; therefore, consideration must be made to provide people with access to no-cost, to them, personal and professional help in making their health plan purchasing decisions. I recommend an Enrollment Fee be paid out to whomever actually assists the person. The assistor could be a licensed insurance agent OR a certified professional, i.e. Certified Community Health Worker. I recommend $100 paid in Feb and in Aug, for continued enrollment, aligned with Open Enrollment, and supporting healthcare employment.